MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General

REPORT TITLE	OTSG APPROVED (Date)
SF4700 (TEST) Presidio of Monterey Health Clinic FluMist® Fluzone® Screening and Administration Form (v 4.2)	

Screening Questions (to be completed by patient) Also complete "PATIENT IDENTIFICATION" at bottom

YES	NO	NOT SURE	
☐	☐		1. Have you had the Flu shot or received FluMist already this season (since Sept 2006)? If so, when (approximate date): _____ and where: _____
☐	☐	☐	2. Are you **allergic to eggs**?
☐	☐	☐	3. Have you ever required medical treatment for an adverse reaction to an influenza vaccine?
☐	☐	☐	4. Do you have a history of **Guillain-Barre'** syndrome?
☐	☐		5. Are you currently **50 years of age or older**, or **less than 5 years old**?
☐	☐	☐	6. Do you have a **weakened immune system** (such as HIV/AIDS, organ transplantation, other immune deficiency)?
☐	☐	☐	7. Are you in contact with anyone with such a severely weakened immune system that people around them must wear a mask, gown, and gloves (such as people who recently had a bone marrow transplant)?
☐	☐	☐	8. Do you have a **chronic medical condition** (such as **asthma**, reactive airway disease, other lung diseases, **anemia** or other blood disorders, diabetes, kidney disease, liver disease, heart disease or stroke)?
☐	☐	☐	9. Are you **pregnant**, or may you be pregnant?
☐	☐	☐	10. Are you **scheduled to deploy** and have not yet received the **smallpox vaccine** or are **scheduled to receive a live vaccine** within the next month such as **MMR, yellow fever, or varicella**?
☐	☐	☐	11. Have you taken **prednisone** (a "steroid pill" often used for severe asthma, poison ivy and other skin conditions) within the **last 6 months**?
☐	☐	☐	12. Are you taking **aspirin** daily **AND** are **17 years or younger**?

If you answered yes to any of the above, a provider will determine if FluMist® or Fluzone® is right for you.

DATE	SIGNATURE OF PATIENT

Provider Clearance (if any "yes" responses above)

☐ **Administer FluMist®:** Spray 0.25 ml in each nostril while recipient is in an upright position.

☐ **Delay FluMist®** until _____

☐ Medical High Risk Condition, **administer Fluzone®:** 0.5 ml intramuscular injection

☐ Medical Contraindications, **do not give** either FluMist® or Fluzone®

DATE	SIGNATURE/NAME OF PROVIDER

Administration Notes

☐ **FluMist®** administered by intranasal spray
Lot number: 500428P
☐ Patient information from www.cdc.gov

☐ **Fluzone®** administered by intramuscular injection
Lot number: _____
☐ Patient information from www.cdc.gov

DATE	SIGNATURE/NAME OF VACCINE ADMINISTRATOR

(Continue on reverse)

PATIENT'S IDENTIFICATION

SSN

RANK DOB

LAST NAME

FIRST NAME

BRANCH SERVICE UNIT

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT